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Commentary

Slow Poisoning? Interests, Emotions, and the Strength of the English NHS

Comment on "Who Killed the English National Health Service?"

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Abstract

Martin Powell makes the point that the death of the National Health Service (NHS) is constantly asserted without criteria. This article suggests that the NHS is many things, which makes criteria unstable. The alignment of interests in the structure of the NHS enables both overheated rhetoric and political strength, and that pluralization of provision might actually undermine that alignment over time.

Keywords: National Health Service (NHS), Politics, Social Policy

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Readers of mystery novels will be familiar with the setup: a murder is said to have been committed, but there is no corpse. Without a body there can be no investigation. In novels, this is a setup for an intrepid private investigator or uncompromising police officer to start investigating. In politics, Martin Powell's article suggests, it is more common to assert the murder, skip the investigation, and go straight to the prosecution.[1] We do not know how to tell if the National Health Service (NHS) has been killed, which makes it hard to identify the weapon or nail the murderer, but lots of people are sure there was a murder and have ideas about who that murderer might be.

1. What Is the NHS?

Powell argues that the "criterion" and "template for evaluation" of claims about the death of the NHS are unclear. We cannot know whether the NHS is dead, let alone who killed it, without some clarity about what its death would mean.

These analytic problems might be disguising something a bit bigger. What, exactly, is the NHS? Is it a set of rights, a sector of the economy, a giant organization, a budget line, an employer, a set of shared expectations, or a million ill-managed public employees?

The answer, as with most large social organizations, is all of the above. The very multidimensionality of the NHS makes it hard to identify criteria and evaluative templates for its death. For example, if it is a mechanism supporting a right to healthcare, then our attention is directed to legal rights and the duty of the government to provide healthcare. Words about duty or responsibility to provide take on a big meaning in the legalistic world of rights because they seem to make rights tangible. If it is a large organization, then we might think about its management and staff and be wary of any threat to its organizational integrity and structure.

Furthermore, many of these characteristics are difficult to divide into binaries. Quality of care cannot be broken into good and bad care. The NHS could remain a big organization delivering free care at the point of access, but if the quality of care were to deteriorate, would there be a point at which we could say it had got so bad that the NHS was dead? Likewise, public provision might be a core feature of the NHS, but it has never been entirely public. What amount of non-public provision, what number of privately employed staff, what growth rate in NHS spending on private providers constitutes a break?

In other words, the NHS is necessarily many things, and the meanings are always shifting because they are in the hands of many people whose preoccupations, desires, thoughts and preferences differ and shift over time. Some reasons to love the NHS, such as its contribution to the economies and middle classes of poor places, are rarely articulated in politics. Others, such as its ability to rescue a troubled neonate without bankrupting the parents, are more commonly articulated. Those who dislike the NHS rarely articulate a principled objection to it. They instead focus on trying to introduce more market forces and profit motivations (with justifications dating to Adam Smith) into a provision that they insist will remain free and universal.

In fact, a number of figures in government since 2010, including the people who led the Liberal Democrats during the first Cameron government and the current Conservative Secretary of State for Health, Jeremy Hunt, *have* called for the abolition of the NHS.[2-4] The favored replacement scheme of Hunt and his coauthors was a voucher arrangement that people could use to purchase healthcare. Conservatives the world over have learned that attacking universal welfare state programs head on is dangerous and have turned to making their operations more conservative in some way, leaving the

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programs alone while reducing benefits, reducing downward redistribution and trying to introduce opportunities for profit.[5] The plans of these leading politicians fits with the basic thrust of conservative, liberal policies worldwide, but they are oddly likely to actually call for the abolition of the NHS, even if their replacement "social insurance" or voucher schemes are hazy.

2. The Usefulness of Criteria

Given that the NHS is many things, it is not clear what plausible criteria might be in even the most dispassionate sense. But the people who speak of the death of the NHS are not dispassionate. Powell's targets are engaged in formal politics (eg, the Labour party) or are highly political, such as campaigning journalist John Lister or campaigning academic Allyson Pollock. They use the kind of rhetoric that works in politics. If we start demanding clear criteria and evaluative templates from politicians and campaigners, we will be frustrated.

It is good academic practice to be clear about concepts, but it is not always clear that it is good political practice. Political language is often instrumental, intended to achieve an objective such as promotion of a particular model of health services. In such language, ambiguity, hyperbole, and negativity are crucial tools. Ambiguity allows the speaker to avoid challenges or opportunistically expand the argument's scope. Hyperbole, meanwhile, can seem necessary to break through the noise and distractions of everyday life. When Conservative and Liberal Democrat members of Parliament (MPs) call for replacing the NHS with something else, they are making a dramatic political statement in just the same way Powell's targets are. Negativity, finally, is useful because of the well-known human tendency to dwell on the negative and on losses. All three suggest that hazy arguments about the ill-defined death of the NHS are to be expected in politics *so long as the NHS is tangible and popular enough for them to work.*

3. Why This Rhetoric?

The question then is: why should rhetoric about killing the NHS be so popular? Conservative politician Nigel Lawson was not alone when he said the NHS was the "closest thing the English have to a religion."[6] Speculatively, the reason is that the NHS is benign in the way all healthcare is benign (bad things are rarely anybody's intention), and it addresses people in a time of need, just like a church. Unlike the Church of England, with which it shares nationwide pretensions and infrastructure, it is close to unavoidable. One can get married outside a church, but it is hard to avoid sharing major life events such as birth and death with the NHS. Even those whose preference is to go private will use NHS resources as they do so and will return completely to its embrace if they need oncological or neonatolological treatment. Given its many advantages – healthcare without a serious financial burden is something anybody can appreciate – it is easy to see how it could be possible to become quite misty-eyed about it. If one's politics appreciate solidarity and redistribution from richer to poorer, let alone public sector workers, then the emotional case for the NHS becomes stronger yet.

In other words, the NHS contains 2 key terms in its name: National and Service. Service means it is a big public sector organization comparable to the military or the Environment Agency; National means it is a project for and of the entire nation and is redistributive between the more and less fortunate.

The common denominator of attacks on the NHS, such as that of Hunt and his colleagues, is precisely a dislike of the "Service" in NHS – the sense that it is not just a right to healthcare at the point of use, but also a very large public organization. They are less likely to say if they resist the "National" if that means that the big public service is also one whose effect is redistributive as well. Given the clear attitudes towards redistribution of many English Conservatives, the appeal of voucher schemes probably includes less redistribution. The NHS was like many creatures of 1940s Labour: a big public organization with some intent to produce equity. As such it is always vulnerable in a political culture where many no longer have an intuitive sympathy for such organizations or their goals.

From this perspective, it is understandable why writers such as Pollock and Lister see infringement on the "Service" aspect of NHS as an attack on the NHS. When Labour under Blair focused on the idea that the NHS should be free and universal at the point of service, it was leaving out public provision. New Labour's idea was to downplay the Service aspect of the NHS in order to strengthen its National character, using competition to improve its efficiency and customer service so that the middle classes would continue to support it rather than becoming focused on it as a public employer. For those who see the Service itself as a crucial part of its identity, and who see that Service ethos as a powerful force for the preservation of the NHS, the result is that Blair's ideas approached treason in the face of Conservative attack.

Naturally, those who like the Service in NHS include unions such as the British Medical Association (BMA), but it also appeals to something deeper. In the broader politics of the welfare state, part of the cross-class appeal of social insurance is that it need not be redistributive. It can be made redistributive, as it is in most social health insurance countries, but it can also be made an effective instrument of insurance that does not redistribute, as is the case in pension politics and used to be the case in German health insurance. The NHS and similar systems unite redistribution and insurance in a way that is difficult to disentangle. Tax financing of a universal right to healthcare insures people against the consequences of ill health, something anybody of any class can appreciate, but also redistributes from those with more money to those with worse health.[7]

Furthermore, health sectors around the world have no shortage of effective interest groups, but the NHS aligns the preferences of a wide variety of groups that might not be united in defense of public provision. Doctors' unions cannot be assumed to have a shared interest in widespread access to healthcare. A system in which they fight for the NHS as doughtily as they do is probably sturdier than the international norm in which their defense of their members' pay and conditions does not sustain universal healthcare access.

Welfare states are partly held together by institutional mechanisms that bind personal interests such as paychecks and income security into larger political forces for redistribution. The NHS is one such mechanism, and the result is that there is a powerful political motivation to preserve the Service in

NHS. That motivation transfers into powerful motivation to defend it against the sorts of contracting, competition, and plural provision schemes that are very common, lucrative, and particularly admired by right wing governments saddled with welfare states they would not have chosen. The appeal to such strong language is plausible because the NHS unites interests of people in almost every class as consumers but also producers.

It also suggests that the critics have a point. If the distinctive thing about the NHS is the way it aligns the interests of people within the big organization with the right to healthcare, then pluralizing provision might indeed be a long-run way to weaken the proponents of universality and redistribution in health. A fragmented, pluralized "NHS" full of small charity providers, consultants, and private sector providers might not have the same symbolic power or alignment of self-interested and altruistic forces behind it. Dramatic statements about the death of the NHS, or the superiority of vouchers, might be the suitably hyperbolic way of talking about such matters in politics.

4. The Political Distinctiveness of the NHS

The NHS is distinctive then, and can be defended, in a way that any functioning national health service system can be defended: as a tangible, visible, sign that we are all in it together, and a redistributive service that is hard to make less redistributive. That characteristic is built into its design. It couples insurance and redistribution in a way that social insurance schemes make complex and optional, and in a way that voucher schemes obscure. The United States' Veterans Health Administration has a similar tangibility and loyalty (and high level of quality), and it is probably no accident that it works much like the NHS.

The NHS shows us that while there are many reasons to stop caring about the basic Bismarck/Beveridge distinction, there are still some reasons to keep caring. Basic characteristics of national health services make the national tangible in the service, make universality attractive to the middle classes, make redistribution part of the income of well off people like doctors, and align the gratitude of patients with a single, concrete, organization wearing a blue logo. We do not know how much we can unravel these closely knitted interests without losing the emotional, political, and functional defense of the NHS, but it seems we might eventually find out.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

SLG is the single author of the manuscript.

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